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Part 2

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985

MAY 23, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 1868 which on April 2, 1985, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce to whom was referred the bill (H.R. 1868) to amend the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions of that Act, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) SHORT TITLE.—This Act may be cited as the "Medicare and Medicaid Patient and Program Protection Act of 1985".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

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SEC. 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128 (42 U.S.C. 1320a-7) is amended to read as follows:

"EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

"SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (as defined in subsection (h)).

"(2) CONVICTION RELATING TO PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

"(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse.

"(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

"(3) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

"(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

"(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license, for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity, or

"(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional conduct, or financial integrity.

"(5) EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (h)).

"(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

"(A) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

"(B) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially

in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

"(C) is—

"(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

"(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

"(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

"(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A or section 1128B.

"(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

"(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

"(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

"(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

"(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

"(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

"(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

"(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary—

"(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

"(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

"(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

"(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

"(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

"(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

"(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

"(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

"(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

Subject to subsection (d)(2), the Secretary shall exercise the authority under this subsection in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

"(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

"(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

"(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

"(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

"(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

"(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion under subsection (b)(12), the period) of the exclusion.

"(B) In the case of an exclusion under subsection (a)(1), the minimum period of the exclusion may not be less than five years.

"(C) In the case of an exclusion under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

"(i) the length of the period in which the individual or entity failed to grant the immediate access described in that subsection, and

"(ii) an additional period, not to exceed 90 days, set by the Secretary.

"(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General)—

"(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

"(B) the period (described in paragraph (2)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

"(2)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (1) shall be the same as any period of exclusion under a program under title XVIII.

"(B) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (1) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

"(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

"(1) promptly notify the appropriate State or local agency or authority, having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

"(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

"(3) request that the State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

"(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual or entity that is excluded (or directed to be excluded) from participation under this section (or is denied termination of the exclusion under subsection (g)) is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) The provisions of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

"(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section (other than under subsection (b)(12)) or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

"(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

"(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

"(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

"(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

"(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term 'State health care program' means—

"(1) a State plan approved under title XIX,

"(2) any program receiving funds under title V or from an allotment to a State under such title, or

"(3) any program receiving funds under title XX or from an allotment to a State under such title.".

SEC. 3. CIVIL MONETARY PENALTIES.

(a) GROUNDS FOR IMPOSITION.—(1) Subsection (a)(1) of section 1128A (42 U.S.C. 1320a-7a) is amended by striking out "the Secretary determines" and all that follows through "; or" and inserting in lieu thereof "the Secretary determines—

"(A) is for a medical or other item or service that the person knows or has reason to know was not provided as claimed,

"(B) is for a medical or other item or service and the person knows or has reason to know the claim is false or fraudulent,

"(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or has reason to know that the individual who furnished (or supervised the furnishing of) the service—

"(i) was not licensed as a physician,

"(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

"(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

"(D) is for a medical or other item or service furnished during a period in which the person was excluded under the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1985), or 1866(b); or".

(2) Subsection (a)(2)(B) of such section is amended by inserting "(or other requirement of a State plan under title XIX)" after "State agency".

(3) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs

under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.".

(4) No civil penalty or assessment may be imposed under section 1128A(a) of the Social Security Act in the case of a claim filed before August 13, 1981, if liability for the amount of the penalty or assessment could not have been imposed with respect to the claim under section 3729 of title 31, United States Code (relating to false claims).

(b) STATUTE OF LIMITATION ON ACTIONS.—Subsection (b)(1) of such section is amended by adding at the end the following new sentences: "The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by personal service or by mailing, by registered or certified mail, the notice required by paragraph (2).".

(c) CONFORMING AMENDMENT.—Subsections (b), (c), (f), and (g) of such section are each amended by striking out "penalty or assessment" and inserting in lieu thereof "penalty, assessment, or exclusion" each place it appears.

(d) PRO-RATED PAYMENT OF RECOVERIES TO STATE AGENCIES.—Subsection (e)(1)(A) of such section is amended by striking out "equal to the State's share of the amount paid by the State agency" and inserting in lieu thereof "bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid".

(e) NOTICE TO STATE AGENCIES.—Subsection (g) of such section is further amended by inserting "the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),' after "professional organization,".

(f) APPLICATION OF SUBPOENA POWER AND INJUNCTIVE POWERS.—Such section is further amended by adding at the end the following new subsections:

"(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II.

"(j) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.".

SEC. 4. CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) TECHNICAL AMENDMENTS.—Section 1909 (42 U.S.C. 1396h) is amended—

(1) by amending the heading to read as follows:

"CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS";

(2) in subsection (a)(1), by striking out "a State plan approved under this title" and inserting in lieu thereof "a program under title XVIII or a State health care program (as defined in section 1128(h))";

(3) in the matter in subsection (a) following paragraph (4), by striking out "this title" the first place it appears and inserting in lieu thereof "the program";

(4) in the last sentence of subsection (a), by striking out "this title" the first place it appears and inserting in lieu thereof "title XIX", and by striking out "this title" the second place it appears and inserting in lieu thereof "that title";

(5) in paragraphs (1)(A), (1)(B), (2)(A), (2)(B), and (3)(A) of subsection (b), by striking out "this title" and inserting in lieu thereof "title XVIII or a State health care program" each place it appears;

(6) in subsection (c), by striking out "or home health agency (as those terms are employed in this title)" and inserting in lieu thereof "home health agency, or other entity for which certification is required under title XVIII or a State health care program"; and

(7) in subsection (d), by striking out "this title" and inserting in lieu thereof "title XIX" each place it appears.

(b) CRIMINAL PENALTIES FOR PHYSICIAN MISREPRESENTATIONS.—Subsection (a) of such section is further amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by inserting "or" at the end of paragraph (4), and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under title XVIII or a State health care program and knows that the individual who furnished the service either—

"(A) was not licensed as a physician, or

"(B) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing),".

(c) REDESIGNATION OF SECTION 1877(d) AS SECTION 1128B(e).—Subsection (d) of section 1877 (42 U.S.C. 1395nn) is redesignated as subsection (e) and is transferred and inserted in section 1909 at the end thereof.

(d) REDESIGNATION OF SECTION 1909 AS SECTION 1128B.—Section 1909, as amended by subsections (a), (b), and (c) of this section, is redesignated as section 1128B and is transferred to title XI and inserted immediately after section 1128A.

(e) REPEAL.—Section 1877 (other than subsection (d) thereof which was transferred under subsection (c) of this section) is repealed.

SEC. 5. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS.

(a) MEDICAID PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking out "and" at the end of paragraph (45),

(2) by striking out the period at the end of paragraph (46) and inserting in lieu thereof "; and", and

(3) by inserting after paragraph (46) the following new paragraph:

"(47) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1919.".

(b) INFORMATION REQUIRED.—Title XIX is amended by adding at the end the following new section:

"INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

"SEC. 1919. (a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 1902(a)(47) is that the State must provide for the following:

"(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

"(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

"(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

"(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

"(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

"(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

"(1) to licensing authorities described in subsection (a)(1),

"(2) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

"(3) to utilization and quality control peer review organizations described in part B of title XI, and

"(4) to State medicaid fraud control units (as defined in section 1903(q)),

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

"(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.".

SEC. 6. OBLIGATION OF HEALTH CARE PRACTITIONERS AND PROVIDERS.

Section 1156 (42 U.S.C. 1320c–5) is amended—

(1) by striking out "title XVIII" and "such title" in subsection (a) and inserting in lieu thereof "this Act" in each instance, and

(2) by striking out "title XVIII" in subsection (b) and inserting in lieu thereof "this Act" each place it appears.

SEC. 7. EXCLUSION UNDER THE MEDICAID PROGRAM.

Section 1902 (42 U.S.C. 1396b) is amended by inserting after subsection (f) the following new subsection:

"(g)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

"(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a health maintenance organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

"(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions), or

"(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B).

"(3) As used in this subsection, the term 'exclude' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.".

SEC. 8. MISCELLANEOUS AND CONFORMING AMENDMENTS.

(a) MATERNAL AND CHILD HEALTH PROGRAM.—Section 504(b) (42 U.S.C. 704(b)) is amended—

(1) by striking out "or" at the end of paragraph (4),

(2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(b) DISCLOSURE REQUIREMENTS.—(1) Subsection (a) of section 1126 (42 U.S.C. 1320a–5) is amended—

(A) in the first sentence, by striking out "or other institution" and all that follows through the period at the end and inserting in lieu thereof "or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8).", and

(B) in the second sentence, by striking out "institution, organization, or agency" and inserting in lieu thereof "entity".

(2) Subsection (b) of such section is amended by striking out "institution, organization, or agency" and inserting in lieu thereof "entity" each place it appears.

(c) MEDICARE PAYMENTS.—(1) Section 1862 (42 U.S.C. 1395y) is amended—

(A) by striking out subsection (d), and

(B) by amending subsection (e) to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation in a program under this title pursuant to section 1128 or section 1128A.".

(2) Section 1842(j) (42 U.S.C. 1395u(j)) is amended—

(A) in paragraph (2)—

(i) by amending subparagraph (A) to read as follows:

"(A) excluding a physician from participation in the programs under this title for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or", and

(ii) by striking out "barred from participation in the program" in the second sentence and inserting in lieu thereof "excluded from participation in the programs"; and

(B) by striking out "bar" in paragraph (3)(A) and inserting in lieu thereof "exclude".

(3) Section 1862(h)(4) (42 U.S.C. 1395y(h)(4)) is amended by striking out "paragraphs (2) and (3) of subsection 1862(d)" and inserting in lieu thereof "subsections (c), (f), and (g) of section 1128".

(4) Paragraph (3) of section 1886(f) (42 U.S.C. 1395ww(f)) is amended to read as follows:

"(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).".

(d) TERMINATION OF PROVIDER AGREEMENTS UNDER MEDICARE.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by striking out paragraph (3) of subsection (a);

(2) by amending subsection (b) to read as follows:

"(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

"(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

"(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

"(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

"(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

"(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(c).";

(3) in paragraphs (1) and (3) of subsection (c), by striking out "an agreement filed under this title by a provider of services has been terminated by the Secretary" and inserting in lieu thereof "the Secretary has terminated or has refused to renew an agreement under this title with a provider of services";

(4) by inserting "or nonrenewal" in subsection (c) after "termination" each place it appears; and

(5) by adding at the end the following new subsection:

"(g)(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.".

(e) CONFORMING AMENDMENT.—Section 1869 (42 U.S.C. 1395ff) is amended by striking out subsection (c).

(f) MEDICAID PLAN REVISIONS.—Section 1902(a) (42 U.S.C. 1396b(a)) is amended—

(1) in paragraph (23), by inserting "subsection (g) and in" after "except as provided in",

(2) in paragraph (38), by striking out "respectively, (A)" and all that follows up to the semicolon at the end and inserting in lieu thereof "the information described in section 1128(b)(9)", and

(3) in paragraph (39)—

(A) by striking out "bar" and inserting in lieu thereof "exclude",

(B) by striking out "person" and inserting in lieu thereof "individual or entity" each place it appears, and

(C) by inserting "or section 1128A" after "section 1128".

(g) DENIAL OF FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.—Paragraph (2) of section 1903(i) (42 U.S.C. 1396b(i)) is amended to read as follows:

"(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or".

(h) OTHER MEDICAID CONFORMING AMENDMENTS.—(1) Subsection (n) of section 1903 (42 U.S.C. 1396b) is repealed.

(2) Paragraph (2) of section 1915(a) (42 U.S.C. 1396n(a)) is amended to read as follows:

"(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

"(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

"(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.".

(i) TITLE XX.—Section 2005(a) (42 U.S.C. 1397d(a)) is amended—

(1) by striking out "or" at the end of paragraph (7),

(2) by striking out the period at the end of paragraph (8) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(j) DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION TO MANUFACTURE, DISTRIBUTE, OR DISPENSE A CONTROLLED SUBSTANCE FOR ENTITIES EXCLUDED FROM THE MEDICARE PROGRAM.—Section 304(a) of the Controlled Substances Act (21 U.S.C. 824(a)) is amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act.".

SEC. 9. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS OF DEFICIT REDUCTION ACT OF 1984.

Section 2373(c) of the Deficit Reduction Act of 1984 (Public Law 98-369; 98 Stat. 1112) is amended—

(1) in paragraph (1)—

(A) by inserting "(whether or not approved)" after "such State's plan",

(B) by inserting "(including any part of the plan operating pursuant to section 1902(f) of that Act), or the operation thereunder," after "Social Security Act", and

(C) by inserting "(or its operation's)" after "such plan's"; and

(2) by adding at the end the following new paragraph:

"(5) In this subsection, a State plan is considered to include any amendment or other change in the plan which is submitted by a State, or for which the Secretary otherwise has notice, whether before or after the date of enactment of the Deficit Reduction Act of 1984 and whether or not the amendment or change was approved, disapproved, acted upon, or not acted upon by the Secretary.".

SEC. 10. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsections (b), (c), (d), and (e), the amendments made by this Act shall become effective at the end of the 14-day period beginning on the date of the enactment of this Act and shall not apply to administrative proceedings commenced before the end of such period.

(b) MANDATORY MINIMUM EXCLUSIONS APPLY PROSPECTIVELY.—Section 1128(c)(3)(B) of the Social Security Act (as amended by this Act), which requires an exclusion of not less than five years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act.

(c) EFFECTIVE DATE FOR CHANGES IN MEDICAID LAW.—(1) The amendments made by sections 5 and 8(f) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning more than 30 days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) Subsection (j) of section 1128A of the Social Security Act (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

(d) PHYSICIAN MISREPRESENTATIONS.—Clauses (ii) and (iii) of section 1128A(a)(1)(C) of the Social Security Act, as amended by section 3(a)(1)(F) of this Act, and subparagraph (B) of section 1128B(a)(5) of the Social Security Act, as amended by section 4(b)(3) of this Act, apply to claims presented for services performed on or after the effective date specified in subsection (a), without regard to the date the misrepresentation of fact was made.

(e) CLARIFICATION OF MEDICAID MORATORIUM.—The amendments made by section 9 apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984.

(f) TREATMENT OF CERTAIN DENIALS OF PAYMENT.—For purposes of section 1128(b)(8)(B)(iii) of the Social Security Act (as amended by section 2 of this Act), a person shall be considered to have been excluded from participation under a program under title XVIII if payment to the person has been denied under section 1862(d) of the Social Security Act, as in effect before the effective date specified in subsection (a).

CHANGES IN EXISTING LAW

For changes in existing law made by the bill as reported, see House Report 99-80, Part 1, pages 28 through 58, as reported by the Committee on Ways and Means on May 10, 1985.

CONTENTS

Purpose and Summary

The basic purpose of the Committee bill is to improve the ability of the Secretary and the Inspector General of the Department of Health and Human Services to protect the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Title XX Social Services Block Grant programs from fraud and abuse, and to protect the beneficiaries of those programs from incompetent practitioners and inappropriate or inadequate care.

The Committee bill has four main elements, the first of which relates to exclusion of participating providers. The bill mandates the exclusion from Medicare and Medicaid of individuals convicted of program-related crimes or patient abuse or neglect. It also broadens the grounds for the discretionary exclusion of health care providers from Medicare and Medicaid. In addition, the bill extends the mandatory and discretionary exclusion remedies to other State health care programs, the Maternal and Child Health Services Block Grant, and the Title XX Social Services Block Grant. The Attorney General is authorized to deny, revoke, or suspend the controlled substances registration of any individual or entity subject to mandatory exclusion from Medicare.

Second, the Committee bill revises the current civil money penalty authorities. It clarifies the Secretary's authority to consolidate exclusion and civil money penalty determinations involving the same provider into a single administrative proceeding, and it broadens the Secretary's authority to seek injunctive relief to protect assets for the payment of civil money penalties imposed. The bill also adds, as grounds for imposing civil money penalties, the submission of claims for payment by individuals who misrepresent that they are physicians or who obtained their licenses through misrepresentation.

Third, the bill provides for criminal penalties for the submission of claims by individuals who are not licensed as physicians or who obtained their licenses through misrepresentation or cheating on a licensing exam.

Finally, the bill requires States, as a condition of receiving Federal Medicaid matching funds, to provide information to the Secretary regarding actions taken against health care practitioners by State licensing authorities. The bill also authorizes the Secretary to provide such information to other State licensing authorities and program agencies in order to protect the health and safety of beneficiaries and the fiscal integrity of the programs.

Background and Need for Legislation

Under current law, the Department of Health and Human Services (HHS) can exclude practitioners from participation in Medicare for a number of reasons:

Conviction of a criminal act against Medicare (Title XVIII), Medicaid (Title XIX) or Title XX of the Social Security Act;

Imposition of a civil monetary penalty for acts against Medicare or Medicaid;

Submitting false claims to Medicare;

Repeatedly providing more services than necessary to Medicare beneficiaries;

Submitting Medicare claims with charges that substantially exceed the practitioner's customary charges;

Providing services to Medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care;

Failing to keep adequate records to demonstrate the need for services rendered.

HHS has the authority to require all States to exclude practitioners from participating in Medicaid only when the practitioner is convicted of a criminal act against Medicare, Medicaid or Title XX, or where HHS has imposed a civil monetary penalty on the practitioner for acts against Medicare or Medicaid.

If HHS excludes a practitioner for the above reasons, HHS is required to notify the State and local agencies responsible for health care licensing or certification of the suspension and request that they invoke sanctions in accordance with applicable State law or policy.

On May 1, 1984, the U.S. General Accounting Office (GAO) issued a report to the Secretary of HHS which concluded that there was a need to expand Federal authority to protect Medicare and Medicaid patients from health practitioners who lose their licenses. The GAO report found that Medicare and Medicaid patients are being treated in some States by health care practitioners whose licenses were revoked or suspended by another State's licensing board because they did not meet minimum professional standards. This occurred because these practitioners move to another State where they have a license and continue to practice. Such practitioners are able to treat Medicare and Medicaid patients because HHS does not have the authority to exclude them from these programs in all States based on licensing board findings and sanctions in one State. Currently, HHS is only empowered to deny payment for services furnished by a practitioner in the State in which he or she has lost a license.

A primary reason sanctioned practitioners were able to move to other States and continue practice was that other States did not learn of the practitioner's previous offenses, or when they did, many months or years had passed. When States are informed, it may take up to three years to sanction practitioners because procedures are lengthy and there is a shortage of personnel. Sanctions

imposed by one State do not automatically result in sanctions being imposed by other States. State licensing laws do not always permit a State to take action based solely on another State's sanction. Further, physicians whose licenses have been revoked can enter the military and practice without a license from the State in which they are located.

Under current law, HHS can exclude practitioners only for acts committed against Medicare, Medicaid and their beneficiaries. As a result, HHS excludes relatively few of those sanctioned by State boards. For example, while State licensing boards in Michigan, Ohio and Pennsylvania sanctioned 328 practitioners between 1977 and 1982, HHS nationwide excluded only 335 practitioners from 1975 to 1982. Also, only 15 of the 328 practitioners sanctioned by the three States were also excluded by HHS.

Further, over seventy percent (70%) of HHS exclusion actions were for criminal violations against the programs. However, fifty-eight percent (58%) of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care.

In addition, HHS is unable to bar individuals or entities from participation that have been convicted of defrauding private health insurers or defrauding other Federal, State or local government programs.

In summary, HHS currently does not have the authority to exclude individuals or entities from Medicare, Medicaid, the Maternal and Child Health Program and Title XX Social Services Program who have been convicted of non-program related crimes such as fraud, financial abuse, neglect of patients or unlawful distribution of a controlled substance. It does not have the authority in all cases to exclude those who have been sanctioned for defrauding or abusing the Medicaid program from participation in Medicare or vice versa. Further, HHS does not have the authority to exclude nationwide those individuals or entities that have lost their licenses to provide health care or have otherwise been sanctioned by a State licensing authority.

SECTION 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS

Mandatory exclusion for program-related crimes (section 1128(a)(1) of the Social Security Act)

The Secretary would be required to exclude from participation in Medicare any individual or entity convicted of a criminal offense related to the delivery of services in Medicare, Medicaid, the Maternal and Child Health Programs under title V, and Title XX Social Services Program. Under the provisions of a new section 1128(d), the exclusion would be for a period of not less than five years.

If the Secretary excluded an individual or entity from Medicare under this provision, the State would be required to exclude such individual or entity from participation in Medicaid, the Maternal and Child Health Program under Title V, and the Title XX Social Services Programs for the same period. (Hereafter, Medicaid, the

Maternal and Child Health Program and the Title XX Social Services Program shall be referred to as the State health care programs.)

If an individual or entity convicted of a program-related offense involving a state health care program has not been furnishing services to Medicare beneficiaries but would be eligible to do so, it is the Committee's expectation that the Secretary would proceed to exclude the individual or entity from Medicare and then direct the states to exclude the party from the state programs. If the individual or entity was a type of provider that would not otherwise be eligible for Medicare payments, the Secretary could call the matter to the attention of the states and urge that they institute exclusion proceedings. In the alternative, the Secretary could follow the exclusion procedure for Medicare and direct the States to exclude the provider from the State health care programs.

While there is currently a mandatory exclusion from Medicare and Medicaid for crimes related to Medicare, Medicaid to Title XX, there is not a minimum period of exclusion specified in the law. This provision would amend current law to require a minimum exclusion of five years for such crimes. The Committee believes that such a minimum exclusion is appropriate, given the seriousness of the offense. The minimum exclusion provides the Secretary with adequate opportunity to determine whether there is a reasonable assurance that the types of offenses for which the individual or entity excluded have not and will not recur. Moreover, a mandatory five-year exclusion should provide a clear and strong deterrent against the commission of criminal acts.

This provision would also extend current law to require mandatory exclusion from the Maternal and Child Health Program and Title XX programs of individual or entities convicted of program-related crimes.

Mandatory exclusion for crimes related to patient neglect or abuse (section 1128(a)(2))

The Secretary would be required to exclude from participation in Medicare any individual or entity convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of health care. The bill would not establish a minimum period for exclusion, but it is the Committee's expectation that the exclusion would normally be for a period of not less than five years.

If the Secretary excluded any individual or entity under this provision, the State would be required to exclude such individual or entity from participation in State health programs for the same period of time. As noted above, the Secretary could exclude from Medicare providers who are eligible to participate but are not doing so, and could follow the Medicare exclusion process to direct states to exclude providers who are not eligible to participate in Medicare.

Under current law, the Secretary does not have the authority to exclude persons who have been convicted of criminal offenses which are not related to Medicare or other State health care programs. This provision would give the Secretary the authority to protect Medicare and the State health care program beneficiaries

from individuals or entities that have already been tried and convicted of offenses which the Secretary concludes entailed or resulted in neglect or abuse of other patients and whose continued participation in Medicare and the State health programs would, therefore, constitute a risk to the health and safety of patients in those programs.

Permissive exclusions

Subsections 1128(b)(1) through (b)(13) would establish discretionary authority for the Secretary to exclude individuals and entities from Medicare for specified reasons. Although the Secretary would have discretion whether to initiate an exclusion proceeding in any particular case, the bill makes it clear that, if the Secretary concluded that an exclusion was warranted, these authorities would have to be exercised in a manner that resulted in the exclusion of the individual or entity from all of the Medicare and state health programs for which the individual or entity was otherwise eligible to participate. Thus, if the provider were eligible to participate in Medicare, the Secretary would exclude the provider from Medicare, even if the provider had not been participating in Medicare, and would simultaneously direct the states to exclude the provider from the state health programs for the same period of time. If the individual or entity were not eligible to participate in Medicare because he or it was a type of provider that is not reimbursed under that program, the Secretary could use the Medicare exclusion procedures to direct the states to exclude the individual or entity from the state health programs for the period of time for which he or it would have been excluded from Medicare.

Authority to exclude for conviction relating to fraud (section 1128(b)(1))

The Secretary would be authorized to exclude any individual or entity convicted under Federal or State law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or financial abuse if such offense was committed either in connection with the delivery of health care or with respect to a program that is financed, at least partially, by any Federal, State or local government.

Under current law, the Secretary does not have the authority to exclude individuals or entities convicted of criminal offenses which are not related to the Medicare or the State health care programs. This provision would permit the Secretary to exclude persons and entities who have already been tried and convicted of offenses relating to their financial integrity, if the offenses occurred in delivering health care to other patients or if they occurred during participation in any other governmental program.

Authority to exclude for conviction relating to obstruction of an investigation (section 1128(b)(2))

The Secretary would be authorized to exclude any individual or entity convicted of interference or obstruction of any investigation into any criminal offense for crimes that would require mandatory exclusion under section 1128(a) or permit exclusion under section 1128(b)(1).

Authority to exclude for conviction relating to controlled substance (section 1128(b)(3))

The Secretary would be authorized to exclude any individual or entity convicted under Federal or State law of unlawful manufacture, distribution, prescription or dispensing of a controlled substance or any other criminal offense relating to a controlled substance.

Authority to exclude for license revocation or suspension (section 1128(b)(4))

The Secretary would be authorized to exclude any individual or entity whose license to provide health care has been suspended or revoked by a State licensing authority or whose license has been otherwise lost for reasons bearing on the individual's professional competence, professional conduct or financial integrity.

The Committee heard substantial testimony from the General Accounting Office, based in its investigation of three States, and form the Inspector General of HHS about the need to protect Medicare and Medicaid patients from practitioners who lose their licenses in one State, move to another State, and continue to treat program beneficiaries. The provisions of this bill would permit the Secretary to exclude such persons from Medicare in all States and to require the State to exclude them from participation in any State health care program.

This provision would also permit the exclusion of individuals or entities who surrender their licenses while disciplinary proceedings involving professional competence, professional conduct or financial integrity are pending. This provision will prevent unfit practitioners from avoiding exclusion through the expedient of surrendering their license before the state can conclude proceedings against them.

Authority to exclude for prior exclusion from Federal health care program (section 1128(b)(5))

The Secretary would be authorized to exclude any individual or entity suspended or excluded from any Federal program involving the provision of health care. Programs included would be those administered by the Department of Defense or the Veteran's Administration, as well as Medicaid and the other state health programs.

Authority to exclude for excessive charges, unnecessary services, or failure of certain organizations to furnish medically necessary services (section 1128(b)(6))

The Secretary would be authorized to exclude any individual or entity the Secretary determines:

(1) submitted requests for payment which contain charges (or costs) substantially in excess of customary charges (or costs);

(2) furnished items or services to patients substantially in excess of the patient's needs or of a quality which fails to meet professionally recognized standards of health care; or

(3) is a health maintenance organization or capitated health plan, approved under Medicare or Medicaid, which has failed substantially to provide medically necessary items or services

as required by law or contract, if the failure has adversely affected or has the likelihood of adversely affecting Medicare or Medicaid beneficiaries.

The first two items of this provision would essentially recodify current law under Section 1862(d)(1), regarding conditions under which Medicare payments may be denied. The provision would also expand current law on these points to include State health care programs. Further, the provision would make it clear that, in determining whether excess services were furnished or there was a failure to provide quality services, the Secretary could examine the provider's health care practices in furnishing services to patients who are not program beneficiaries.

The new provisions affecting health maintenance organizations and capitated plans are intended to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions. The Committee intends for the Secretary to examine whether there was a deliberate omission or a pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. It is also expected that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards. The Committee expects that these standards could be developed by physicians involved with prepaid group practice, other HMOs and CMPs or standards used by State agencies that have contracts with HMOs.

Authority to exclude for fraud, kickbacks, and other prohibited activities (section 1128(b)(7))

The Secretary would be authorized to exclude any individual or entity that has committed an act described in 1128A (relating to civil money penalties for false or fraudulent claims) or in the new section 1128B (relating to criminal penalties for kickbacks and bribes). (See discussion below regarding the new section 1128B.) The Secretary could exercise this authority to exclude an individual or entity, without the necessity of imposing a civil money penalty or obtaining a criminal penalty or obtaining a criminal conviction. It is the Committee's intent that the burden of proof requirements under this authority would be those customarily applicable to administrative proceedings.

Authority to exclude entities controlled by a sanctioned individual (section 1128(b)(8))

The Secretary would be authorized to exclude any entity that has a person with an ownership or controlling interest, or that has an officer, director, agent or managing employee, who has been convicted of certain program-related offenses (described in section 1128(b) (1), (2), or (3)) or against whom a civil monetary penalty has been assessed or who has been excluded from participation in Medicare or a State health care program.

The section would recodify section 1128(b) of current law with respect to excluding entities that have an individual in an ownershp or control position who has been excluded or sanctioned by the program on the basis of a program-related conviction. This provision

would expand the current exclusion authority, to include entities that have a person in an ownership or control position who has been excluded from Medicare or the other State health care programs or who has had a civil monetary penalty imposed against him.

Authority to exclude for failure to make certain disclosures (section 1128(b)(9), (10) and (11))

The Secretary would be authorized to exclude any individual or entity which fails fully and accurately to make any required disclosure regarding persons with ownership or control or persons convicted of program-related crimes, or fails to supply to the Secretary requested information pertaining to the ownership of subcontractors or to significant business transactions. In addition, the Secretary would be permitted to exclude any individual or entity that fails to provide information that the Secretary determines is necessary to determine amounts payable or refuses to permit examination of its fiscal or other records as may be necessary to verify such information.

These provisions are essentially a recodification of current law under section 1866(b)(2), with an expansion in the entities covered and an extension to include exclusions from the State health care programs.

Authority to exclude for failure to grant immediate access (section 1128(b) (12))

The Secretary would be authorized to exclude an individual or entity that fails to grant, upon reasonable request, immediate access to the Secretary, State agency, Inspector General, or State Medicaid fraud control unit for the purpose of performing their specified statutory functions. The Secretary would be required to define by regulation what constitutes immediate access and a reasonable request. The period of exclusion would be equal to the period during which access was denied and an additional period not to exceed 90 days as set by the Secretary.

Authority to exclude for failure to take certain corrective actions (section 1128(b) (13))

The Secretary would be authorized to exclude any hospital which fails to comply substantially with a corrective action necessary to prevent or correct inappropriate admissions or practice patterns under the prospective payment system, if required to do so under the provisions of section 1886(f)(2) pertaining to the review and recommendations of a peer review organization. This provision clarifies the sanctions available under current law and extends them to include exclusion from the State health care programs.

Due process (sections 1128(c),(d),(e)(f) and (g))

All mandatory and permissive exclusions under Section 1128 and 1128A would be effective at such time, and upon such reasonable notice to the public and to the individual or entity to be excluded, as may be specified in regulation. An exclusion would be effective on or after the effective date specified by the notice of the exclusion.

In order to avoid disruptions in care that would be harmful to patients, and to permit an orderly transfer to another provider, payment to an excluded provider would normally be permitted under Medicare, and a State health care program, for up to 30 days, for inpatient institutional services furnished to an individual admitted prior to the exclusion and for home health services or hospice care furnished pursuant to a plan of care established before the date of the exclusion. However, the Secretary could stop payments for such patients sooner than thirty days after exclusion, if the Secretary concluded that the risk to the health or safety of the patients was sufficiently serious to warrant a more immediate transfer to a different provider.

Under the bill, the notice of the exclusion would be required to state the minimum period of exclusion. The period could not be less than five years for an exclusion under the program-related crimes provision in Section 1128(a)(1). Otherwise, the period of exclusion would be within the discretion of the Secretary, taking into consideration such factors as the seriousness of the offense, whether there was an adverse impact on beneficiaries, and whether there are any mitigating circumstances, such as the availability of alternative providers of necessary health care services.

The individual or entity excluded under Section 1128 would be entitled to reasonable notice and opportunity for a hearing by the Secretary, after the notice of exclusion, and to judicial review of the Secretary's final decision. These are the same notice and post-termination hearing requirements provided under present law in Sections 1862(d), 1128 and 1156.

There are currently several different procedural regulations governing the various provisions available to the Secretary to sanction individuals and entities. Although similar in many respects, the regulations also vary sufficiently that affected parties can become confused about the correct, applicable procedures. Since the Committee's bill consolidates these authorities, and the Committee understands their administration will be consolidated under the responsibility of the Inspector General, the Committee intends that the Secretary promulgate a uniform set of procedural regulations.

The provisions of section 205(h) of the Social Security Act have been expressly incorporated in the bill to make clear that the review process provided for in the bill shall be the exclusive means of review for questions arising under this section (and under sections 1128A and 1156).

The Secretary would be required to notify promptly the appropriate State agencies of an exclusion from Medicare under Section 1128. Each State would be required to exclude or otherwise bar an excluded individual or entity from its State health care programs for the same period as the Medicare exclusion, unless the State requested and received a waiver from the Secretary, based on a judgment that the exclusion will result in program beneficiaries' not having adequate access to appropriate services.

An individual or entity excluded from participation under Section 1128 (or Section 1128A) would be permitted to apply to the Secretary for reinstatement under Medicare and the State health care programs after a period of exclusion specified in the notice. The Secretary could reinstate such individual or entity if the Secre-

tary determined that there was no basis for a continuation of the exclusion and there were reasonable assurances that the types of actions which were the basis for the original exclusion had not recurred or would not recur. The Secretary would consider the conduct of the applicant which occurred after the date of the notice of exclusion or conduct which was unknown to the Secretary at the time of the exclusion, in making this determination.

This provision also amends current law to provide for administrative and judicial review of a denial of an applicant for reinstatement. The Committee believes that such review is appropriate, in order to provide excluded individuals and entities a safeguard against the possibility of arbitrary denials of reinstatement. However, the Committee intends that the decision of the Secretary should be accorded deference in this review process. The Committee also intends for the Secretary to set forth in regulations the frequency with which applications for reinstatement can be made, in order to prevent unduly repetitious submissions of such applications.

SECTION 3. CIVIL MONETARY PENALTIES (SECTION 1228A OF THE SOCIAL SECURITY ACT)

Under current law, the Secretary is authorized to impose a civil monetary penalty (of up to $2,000 per item or service), plus an assessment of twice the amount claimed, on any person who files a claim for a medical or other item or service that the person knew or had reason to know was not provided as claimed.

Under current law, in section 1128(c), the Secretary is also authorized to exclude a person, against whom a civil money penalty or assessment has been imposed, from Medicare and to direct his exclusion from Medicaid. The Committee bill consolidates and clarifies these authorities, along with some expansion of the grounds for penalties and exclusion.

The bill makes several clarifying amendments to the civil monetary penalty statute. First, the bill amends the statute to make actionable those claims a person knew or had reason to know were "false or fraudulent". This amendment is intended to clarify that the scope of the statute includes such conduct as double billings, but is not intended to change the current standard of proof regarding the requirement that a person knew or had reason to know the claim was wrongful.

The bill further clarifies the statute by expressly providing that the submission of claims for physicians' services, or items or services incident to a physicians' services, which are furnished or supervised by a non-licensed physician are actionable under the statute. In addition, the bill expands the statute's coverage to encompass claims for such items or services where the physicians' license was obtained through material misrepresentations or where the physician falsely represented to the patient that he or she was board-certified in a medical specialty.

Under current law, civil money penalties apply to any individual or entity who causes to be presented to any person a request for payment in violation of an agreement with a State Medicaid agency not to charge a person for an item or service in excess of

the amount of allowable payment under the State's Medicaid plan. The committee bill clarifies that this applies not only to those providers who have a formal agreement with the State Medicaid Agency, but to any providers participating in the State's Medicaid program. All participating providers are subject to the general State plan requirement that they accept Medicaid payment rates as payment in full for services rendered. Providers that bill Medicaid patients for any amounts (other than copayments required under the State Medicaid plan) with respect to covered services are subject to civil money penalties.

The Committee notes a clarification of intent with respect to the definition of "item of service" in section 1128A(h)(3) of the current statute. Since the enactment of the civil monetary penalty statute, the Congress has enacted the prospective payment system (PPS) for inpatient hospital services furnished under Medicare (section 1866 of the Social Security Act). Consequently, hospitals now bill Medicare for a hospital inpatient stay and receive a payment that encompasses all the hospital inpatient services furnished during that stay. This change in the mechanism and documentation by which hospitals make claims for services under PPS does not affect their status as claims for items or services within the meaning of section 1128A. Other examples of information that hospitals provide under PPS that may constitute a claim include diagnostic and procedural information, cost reports, reports on the numbers and time allocation of interns and residents, and length of stay information.

Under the bill, the Secretary's authority to exclude a person against whom a civil monetary penalty or assessment is imposed would be relocated from section 1128 to section 1128A. The intent of this change is to make explicit the policy that the Secretary may use a single administrative procedure both for imposition of penalties and assessments and for exclusions.

The Committee's bill, in the new section 1128(b)(7), would also authorize the Secretary to exclude an individual or entity who commits an act that would be a basis for a civil money penalty under section 1128A. This, the Committee bill would give the Secretary two alternative procedures for exclusion. The Secretary could use section 1128, which does not involve civil money penalties and for which the opportunity for hearing follows the notice of exclusion, or could use section 1128A, which combines actions for exclusion and civil money penalties and which offers an opportunity for hearing prior to the exclusion and penalty. It is the Committee's intent, however, that the Secretary choose one or the other alternative in each instance and that the Secretary not subject an individual or entity to both procedures on the same set of facts.

By consolidating the exclusion and penalty provisions in section 1128A, the bill would also provide a single forum for judicial review of such penalties, assessments and exclusions. Under current law, civil monetary penalties and assessments are subjects to review by the Court of Appeal; whereas, exclusions based on them under section 1128 are subject to review under Section 205(g) in the district courts. This bill would consolidate review in the Courts of Appeal.

In the case of claims filed before August 13, 1981 (the effective date of the civil monetary penalty law), the bill provides that no

civil monetary penalty or assessment can be imposed in excess of what could have been imposed under the False Claims Act (31 U.S.C. 3729) for the same conduct. The intent of this provision is to clarify the standards applicable in proceedings under this statute involving such claims.

Under the bill, the Secretary would not be permitted to initiate an action under the civil monetary provisions late than six years after a claim had been presented. This is the same period provided in the False Claims Act (31 U.S.C. 3731). In addition, the section clarifies that actions may be initiated either by mailing notices by registered or certified mail, or by delivery to Respondent.

A State's share of funds collected under the civil monetary penalty statute in cases involving Medicaid claims would be increased under the bill. Under current law, the State recovers only its share of the Medicaid funds actually paid as a result of false claims. Under the bill, the State would be paid a portion of the total amount collected under the civil monetary penalty statute, in proportion to its share of the amount it paid for the claims on which the amount collected is based. The intent of this provision is to encourage states to develop and refer civil monetary penalty cases to the Secretary, and to recompense them for their investigative and support services in civil monetary penalty cases.

The bill would authorize the Secretary to issue and enforce subpoenas with respect to civil monetary penalty proceedings to the same extent the Secretary has such authority in other Medicare and Medicaid matters.

If the Secretary has evidence that any person has engaged, is engaging or is about to engage in any activity which makes the person subject to a civil monetary penalty, the Secretary would be permitted to bring an action in district court to enjoin such activity or to enjoin such persons from concealing, removing or encumbering assets which may be required in order to pay a civil monetary penalty, or to seek other appropriate relief, including receivership. This provision is modeled on the injunctive authorities of other government agencies with anti-fraud responsibilities, namely, the Securities and Exchange Commission (See 15 U.S.C. 77t) and the Federal Trade Commission (See 15 U.S.C. 53(b)). It is intended that district courts will grant the Secretary appropriate relief based upon evidentiary showings which are no more burdensome than evidentiary showings required of those agencies.

SECTION 4. CRIMINAL PENALTIES FOR CERTAIN FRAUD AND ABUSE RELATED TO MEDICARE AND MEDICAID (SECTION 1128B OF THE SOCIAL SECURITY ACT)

The bill would relocate the kickback, bribe and false statements provisions of Medicare (currently Section 1877) and Medicaid, (currently Section 1909) into a new Section 1128B. The scope of these provisions would be broadened to encompass offenses against the Maternal and Child Health Program and the Title XX Social Services Program. The provisions would also be clarified to expressly include certain physician misrepresentations.

SECTION 5. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS (SECTIONS 1902(A)(47) AND 1919 OF THE SOCIAL SECURITY ACT)

A State would be required to have in effect a system of reporting information with respect to formal proceedings concluded against an individual or entity by the State licensing authority.

The State would be required to maintain a reporting system on any adverse actions taken by such licensing authority, including any revocation or suspension of a license, reprimand, censure or probation; any dismissal or closure of a proceeding by reason of the practitioner or entity surrendering the license or leaving the State; and any other loss of license whether by operating of law, voluntary surrender, or otherwise.

The State would be required to provide the Secretary or an entity designated by the Secretary access to such information for purposes of carrying out this Act. The information must be supplied to the Secretary or, under other suitable arrangements made by the Secretary, to another entity in such a form or manner as determined by the Secretary. Information would be required to be provided to State licensing authorities and to the State health care programs as well.

The Committee believes that there are other organizations which are currently collecting information on revocation, suspension, censure, and other licensure action against health care professionals which the Secretary might determine could adequately perform collection functions on behalf of the Medicare and Medicaid programs. The Secretary may find that it is not necessary to duplicate these collection processes. Therefore, the bill would leave to the Secretary the discretion to determine who might most appropriately collect the information. If the Secretary decides to use another organization for the collection and dissemination of information, it is incumbent upon the Secretary to ensure that any organization chosen can provide the information in a timely manner and in a useful form.

Further, the Committee believes that it would be an excessive burden for the Secretary to collect information on all actions commenced or still pending before a State licensure board. Thus, the bill provides only for the collection of completed actions.

The Committee anticipates that the Secretary may wish to use peer review organizations to review the actions of State boards to assist in determining whether the loss of a license involved professional competence, professional conduct, or financial integrity.

The Secretary would be required to provide suitable safeguards to ensure the confidentiality of the information furnished by State licensing authorities.

SECTION 6. OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS (SECTION 1156 OF THE SOCIAL SECURITY ACT)

The bill would amend section 1156 of the Social Security Act, which currently sets forth the obligations of physicians and other practitioners treating Medicare patients to provide quality of care which is medically necessary and appropriately documented and provides for the exclusion from Medicare of practitioners who,

upon the review and recommendation of a Utilization and Quality Control Peer Review Organization, are found to have violated those obligations. The amendment would extend those obligations to encompass all health care services for which payment may be made under the Social Security Act, not just Medicare. Further, the exclusion authority would be extended to encompass violations occurring in, and exclusion from, any health care program for which payment may be made under the Social Security Act.

SECTION 7. EXCLUSION UNDER THE MEDICAID PROGRAM (SECTION 1902(g) OF THE SOCIAL SECURITY ACT)

The Committee bill clarifies current Medicaid law by making express the authority of States to exclude individuals or entities from participation in their Medicaid programs for any of the reasons that constitute a basis for an exclusion from Medicare under sections 1128, 1128A, or 1866(b) of the Social Security Act. This provision is not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid program.

The Committee bill also requires States to exclude from their Medicaid programs certain organizations or entities receiving Medicaid funds on a prepayment basis, whether as health maintenance organizations under section 1903(m) or as a case management arrangement under section 1915(b)(1). The State would be required to exclude such organizations or entities in either of the following cases.

First, mandatory exclusion would apply whenever a person with an ownership or control interest in the organization or entity, or a person who is an officer, director, agent, or managing employee, has (1) been convicted of a program-related crime, a crime relating to patient abuse, a crime relating to fraud or financial abuse, obstruction of a criminal investigation, or a crime relating to a controlled substance; (2) had a civil monetary penalty assessed against him or her; or (3) been excluded from participation in Medicare or Medicaid or another State health program. Exclusion would be required whether or not the Secretary had actually excluded the person from Medicare under section 1128(b)(8).

Second, mandatory exclusion would apply whenever an organization or entity has, directly or indirectly, a substantial contractual relationship with a person who is convicted, assessed, or excluded as in the first case, above. The purpose of this provision is to exclude from the program organizations or entities from which an unqualified individual benefits financially in a substantial way, for example through a consulting arrangement of some kind, even though the individual does not meet the statutory definition of a person with an ownership or control interest or an officer, director, agent, or managing employee. The provision is not intended to reach normal, arms-length commercial transactions in which a supplier or other contractor happens to have an employee who has been convicted of a crime but who has no relationship with the organization or entity.

The exclusion would be mandatory only with respect to such organizations or entities when they are operating on a prepayment

or risk basis. The State could, if it so chose, allow such organizations or entities to participate in the program on a fee-for-service basis, assuming of course that the organization or entities were otherwise qualified to participate and not subject to exclusion.

Failure on the part of the State to exclude organizations or entities in such cases would result in the loss of Federal Medicaid matching payments for any payments the State makes to any health maintenance organizations or case management arrangements. Matching payments would be disallowed from the date the organization or entity first begins receiving Medicaid funds on a prepayment basis, or on the date the individual is convicted, assessed, or excluded as specified, whichever occurs last.

In the view of the Committee, the incentives for underservicing in order to maximize financial gain are extremely strong in a Medicaid prepayment context, particularly where the proportion of Medicaid patients enrolled in a particular plan is large. Experience in California in the early 1970's, and in other States in more recent times, demonstrates that Medicaid patients, who by definition are poor, are far more vulnerable than affluent consumers to the denial of medically necessary care in a prepayment setting, and that Medicaid taxpayer dollars are at risk of being diverted to uses other than the delivery of medical services.

As explained in the discussion of proposed section 1128(b)(6)(C), above, the Committee bill establishes, as one of the grounds on which the Secretary may exclude an entity from the Medicare and State health programs, the substantial failure of a health maintenance organization or a case manager to provide medically necessary items and services to Medicaid beneficiaries. To further assure that Medicaid patients enrolled under prepayment arrangements will receive medical care that meets acceptable standards, and also to protect the Medicaid program from financial abuse, the Committee bill would require the exclusion of organizations or entities which have associated with them individuals against whom criminal or civil sanctions have been imposed. The purpose of this provision is to maximize the likelihood that only reputable, legitimate organizations and entities are allowed to deliver services to Medicaid patients on a prepayment basis. The Secretary is without authority to waive this provision.

In order to assure that it will receive Federal Medicaid matching funds in connection with its prepayment arrangements, a State will have to assure that the organizations or entities with which it has contracted are not subject to exclusion under this provision. The Committee expects that the Secretary, in implementing this section, will direct the States to screen all prepayment contractors for compliance with these requirements prior to initial participation and no less frequently than each contract renewal period thereafter.

SECTION 8. MISCELLANEOUS AND CONFORMING AMENDMENTS

Denial, revocation or suspension of registration to manufacture, distribute or dispense a controlled substance

The bill would amend the Controlled Substances Act to add as a basis for the Attorney General to deny, revoke, or suspend a regis-

tration to manufacture, distribute or dispense a controlled substance for any individual or entity that has been convicted of a criminal offense related to such individual's or entity's participation in the delivery of items or sevices under Medicare, Medicaid, the Maternal and Child Health Program or Title XX Social Services Program.

The bill would amend titles V (Maternal and Child Health Program) XIX (Medicaid) and Title XX (Social Services Program) to clarify that no payment could be made for any item or service furnished by an individual or entity excluded from participation in those programs.

The bill would also amend title XVIII (Medicare) to provide that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both Section 1128 and Section 1866(b)(2) (termination of provider agreements) with respect to a determination or determinations based on the same underlying facts and issues.

In addition, it makes other technical and conforming amendments to the Social Security Act.

SECTION 9. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS OF THE DEFICIT REDUCTION ACT OF 1984

The Committee bill clarifies that the current moratorium on the Secretary's imposition of any fiscal or other penalties on State Medicaid programs applies to State Medicaid plans, and State Medicaid program operations, whether approved or not, in all States. The content and reasoning of the Medicaid Action Transmittal No. 85–1, issued by the Health Care Financing Administration in January, 1985, in an apparent effort to nullify the moratorium, are specifically rejected.

Section 2373(c) of the Deficit Reduction Act of 1984, P.L. 98–369, prohibits the Secretary of Health and Human Services from taking any compliance, disallowance, penalty, or other regulatory action against a State because the State uses less restrictive standards or methodologies in determining the eligibility of Medicaid beneficiaries who do not receive cash assistance than it uses for those who do. The prohibition applies during a moratorium period that began on enactment of P.L. 98–369 (July 18, 1984) and will end 18 months after the Secretary submits to Congress her recommendations on the application of cash assistance eligibility standards and methodologies to the "medically needy" and other non-cash Medicaid eligibles.

In January, 1985, the Health Care Financing Administration issued a Medicaid Action Transmittal (85–1) to all State Medicaid agencies setting forth HCFA's interpretation of the moratorium provision of the Deficit Reduction Act. The Transmittal concludes that the moratorium applies only where the "existing approved State plan" is or would be in violation of the requirement, as interpreted by HCFA, that the States apply the same methodology or standards to their non-cash assistance Medicaid beneficiaries as they apply to their cash assistance recipients. The Transmittal concludes, "Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of

section 1902(a)(10)(C)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods."

This interpretation is completely erroneous and flatly inconsistent with the intent of Congress. It finds no support whatsoever in the text of section 2373(c) of the Deficit Reduction Act itself, nor in the extensive Joint Statement of Managers of the Committee of Conference (H.Rep. 98–861, pp. 1366–1368), and the Committee is frankly at a loss to understand how HCFA could have so badly misread the provision. The Department's interpretation will lead to precisely the result that the moratorium was intended to avoid: grave administrative problems and serious fiscal difficulties for the States, and great hardship for Medicaid applicants and beneficiaries.

The Committee bill clarifies that the moratorium on the Secretary's sanction activities applies. It applies to State Medicaid plans, whether or not approved, as well as the operation or administration of a Medicaid program by a State agency pursuant to that State plan. It applies to any amendments to, or other changes in, a State plan, regardless of when the amendment or other change came to the Secretary's attention, and regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the amendment or change. It applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Security Income). It applies to Medicaid eligibility and quality control reviews and error rates for past and future periods. The moratorium applies.

The Committee expects that the Secretary will, immediately upon enactment of this provision, notify the State Medicaid agencies that Medicaid Action Transmittal 85–1 is null and void and that a moratorium on compliance, disallowance, penalty, and other regulatory actions is in effect as provided by section 2373(c) of the Deficit Reduction Act of 1984, as amended by the Committee bill.

SECTION 10. EFFECTIVE DATES

Except as specifically provided otherwise, the amendments made by this bill would become effective at the end of the 14-day period beginning on the date of enactment and would not apply to administrative exclusion or civil monetary penalty proceedings commenced before the end of such 14-day period. Exclusions under the bill which are based on convictions under Federal or State law could be imposed with respect to convictions that occurred prior to enactment. However, the mandatory five-year minimum exclusion for program-related convictions would only apply to convictions occurring on or after the date of enactment.

The provisions of the legislation requiring states to provide the Secretary or the Secretary's designee with information in a form and a manner determined by the Secretary would be effective with respect to Medicaid payments for calendar quarters beginning more than 30 days after enactment. Similarly, certain conforming

amendments made in Medicaid would become effective on the same date.

Where a state is required to enact legislation in order to conform with the requirements of this legislation, the state would not be considered to have failed to meet the requirements before the first day of the first calendar year beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act.

The provisions involving physician misrepresentations would only apply to claims filed after the effective date of this legislation. However, some physician misrepresentations are already subject to sanctions under current law and these would not be affected by the bill with regard to claims filed prior to enactment. The filing of claims for physician services (or services incident to physician services), where the individual furnishing or supervising that service is not licensed in the state where the service is rendered, is already a violation of the criminal provisions of the Social Security Act where it is done knowingly and willfully. It is also a violation of current section 1128A, if done knowingly or with reason to know. The amendments in this bill should not be construed to mean that such conduct occurring prior to the enactment of this legislation is not actionable under those current provisions.

Hearings

The Committee's Subcommittee on Health and the Environment along with the Subcommitte on Health of the Committee on Ways and Means held 1 day of hearings on H.R. 1370 and the related bills H.R. 1369 and H.R. 1091 on March 19, 1985. Testimony was received from 9 witnesses, representing 9 organizations, with additional material submitted by 8 individuals and organizations.

Committee Consideration

On Thursday, April 4, 1985 the Subcommittee on Health and the Environment met in open session and ordered reported the bills H.R. 1868 and H.R. 1369 a voice vote, a quorum being present. On May 9, 1985, the Committee met in open session and ordered reported the bill H.R. 1868 with amendment by voice vote, a quorum being present.

Committeee Oversight Findings

Pursuant to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

Committee on Government Operations

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will

reduce the expenditures under Medicare, Medicaid, and the Maternal and Child Health Services Block Grant attributable to fraud or abuse.

Congressional Budget Office Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 15, 1985.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has reviewed H.R. 1868, as ordered reported by the Committee on Energy and Commerce on May 9, 1985. This bill amends the Social Security Act to protect beneficiaries under health care programs of that act from unfit health care practitioners, and to otherwise improve the antifraud provisions of that act. The bill also amends the Controlled Substances Act and the Social Security Act to deny, revoke, or suspend the registration of manufacture, distribute or dispense a controlled substance for entities excluded from reimbursement under the Medicare program.

Based on this review, it is expected that no additional cost to the government will be incurred as a result of enactment of this legislation. Although certain health care practitioners will be excluded from participation in Medicare, Medicaid, and Maternal and Child Health program, and Title XX Social Services, it is expected that beneficiaries will continue to receive the same level of services from other providers. This legislation is not expected to affect the budgets of state and local governments.

We would be pleased to respond to any questions you may have on this estimate. Your staff may contact Jack Rodgers (226–2820) with detailed questions.

With best wishes,
Sincerely,

James Blum
(For Rudolph G. Penner).

Inflationary Impact Statement

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the reported bill will have no inflationary impact, and will lead to a reduction in the amount of Federal funds diverted by health care fraud and abuse.

Agency Views

May 17, 1985.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Dingell: We take this opportunity to inform the Committee of the views of the Administration on H.R. 1868, as ordered reported by the House Committee on Ways and Means on May 2,

which is to marked up on May 8 by the full Energy and Commerce Committee.

H.R. 1868 makes amendments to the Social Security Act to strengthen the provisions intended to deter and sanction fraud and abuse affecting Medicare, Medicaid, and the other health care programs under the Act. The bill would close loopholes and eliminate ambiguities in existing legislation, and would greatly improve coordination among Federal, State, and local agencies to ensure effective enforcement of these provisions.

The amendments would help to protect beneficiaries of health care programs under the Act from unfit health care programs under the Act from unfit health care practitioners, and would improve the ability of the Federal and State governments to deter fraudulent and abusive practices, and to recover monetary losses due to fraud and abuse.

The Administration warmly endorses the objectives of H.R. 1868, and supports the great majority of the provisions of this bill as reported by the Subcommittee. Indeed, the bill is very similar to the Administration's bill, which has been developed by the staff of this Department. However, the Administration opposes section 9, which is unrelated to the objectives of H.R. 1868. The Administration's bill is in the final stages of clearance, and will be transmitted to the Congress in the near future. That bill contains some provisions which we prefer to the corresponding provisions of H.R. 1868, and some additional provisions which we believe would strengthen this legislation.

We have various minor and technical concerns with H.R. 1868; Department staff have been working with staff of the Energy and Commerce and Ways and Means Committees to resolve these. Staff of this Department and of the Department of Justice are reviewing closely those provisions of the bill adding explicit authority for civil and criminal sanctions on individuals who make false representations concerning their certification to practice medicine, to determine whether these provisions are unnecessary or create legal problems. The Department of Justice staff, as well as our own, stand ready to assist the Committee in perfecting H.R. 1868.

In addition, we wish to note our objection to section 9 of H.R. 1868, which would expand the moratorium enacted by section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA) on the requirement that eligibility of the "medically needy" be determined using the same methodology that would be used to determine eligibility for the cash assistance programs. The Department is preparing the report required under section 2373(c) of DEFRA and, until that report has been presented to and considered by the Congress, any broadening of the moratorium is inappropriate.

Finally, we understand that the House Ways and Means Committee adopted, as an amendment to H.R. 1868, the substance of H.R. 1369. Since that bill amends the Controlled Substances Act, but would have no substantive effect upon the programs of this Department, we defer to the views of the Department of Justice on the merits of that amendment.

In summary, if H.R. 1868 were amended to delete section 9 and to make other appropriate minor changes in response to the Ad-

ministration's concerns, we would strongly support the bill insofar as the programs administered by this Department are concerned.

The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

LAWRENCE J. DENARDIS,
Acting Assistant Secretary for Legislation.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown in Part 1 of this report.

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